STATE OF MICHIGAN

DEPARTMENT OF ENERGY, LABOR AND ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner

In the matter of the Nurse Specialists
Provider Class Plan Determination
Report pursuant to Public Act 350 of 1980
_____/ No. 08-056-BC

Issued and entered
This 7TH day of January 2009
by Ken Ross
Commissioner

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to Public Act 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of the Office of Financial and Insurance Regulation (Commissioner) issued Order No. 08-032-BC on July 7, 2008, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of his intent to make a determination with respect to the nurse specialists provider class plan for calendar years 2006 and 2007.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.

2. BCBSM has complied with all applicable provisions of the Act.

3. All procedural requirements of the Act have been met.

4. The staff reviewed relevant data pertaining to the nurse specialists provider class plan as discussed in the attached report, including written comments received during the input period on the provider class plan. The input period was designed to provide the public with an opportunity to present data, views, and arguments with respect to the nurse specialists provider class plan.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

III

ORDER

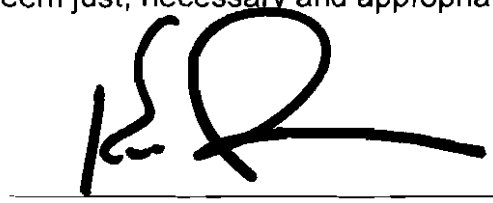
Therefore, it is ORDERED that:

1. The attached nurse specialists provider class plan determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the nurse specialists provider class plan for the calendar years 2006 and 2007.

2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.

3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.



Ken Ross
Commissioner

NURSE SPECIALISTS

PROVIDER CLASS PLAN

DETERMINATION REPORT

for calendar years 2006 and 2007

Office of Financial and Insurance Regulation

State of Michigan

NURSE SPECIALISTS

PROVIDER CLASS PLAN

DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to Public Act 350 of 1980, this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Nonprofit Health Care Corporation Reform Act for calendar years 2006 and 2007. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 2006-2007 nurse specialists provider class plan annual report, public testimony, additional data requested of BCBSM, and information on file with respect to this provider class plan. This material was supplemented as necessary by data from published sources. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balance among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to specialized nursing services whenever necessary. In analyzing BCBSM's performance on the access goal, consideration was given to the formal participation rates of nurse specialists. BCBSM was able to maintain a formal participation rate averaging 80% with all three types of nurse specialists during the two year period under review. The three types of specialty nurses include certified nurse practitioners (CNPs), certified nurse midwives (CNMs) and certified registered nurse anesthetists (CRNAs). Further, CNMs and CRNAs accepted BCBSM's approved amount as payment in full an average of 97% of the time during the same time period. (CNPs only participate with BCBSM on a formal participation basis at this time). BCBSM also instituted a variety of ways for providers to keep informed about BCBSM programs and policies. As such, it is determined that BCBSM generally met the access goal stated in the Act for calendar years 2006 and 2007. BCBSM is encouraged, however, to make a conscientious effort to implement the necessary system changes to expand coverage for certain CNM services that it has agreed is appropriate during calendar year 2009.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for specialized nursing services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 2006 and 2007, BCBSM continued to monitor nurse specialists' qualification standards, and implemented and maintained a variety of quality control standards and utilization management initiatives. BCBSM kept the lines of communication open with nurse

specialists providers through its monthly publication of the *Record*, provider manuals and appeal processes and by holding periodic liaison meetings with the Michigan Nurses Association. BCBSM also sponsored wellness programs to encourage members to adopt healthier, more active lifestyles. It is therefore determined that BCBSM met the statutory goal for calendar years 2006 and 2007.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated to be 4.9% for the period under review. As the rate of change in the total corporation payment per member for the nurse specialists provider class has been calculated to be an increase of 7.8% over the two years being reviewed, BCBSM did not meet the cost goal stated in the Act for 2006 and 2007.

Overall Balance of Goals

In summary, although BCBSM did not substantially achieve one of the three statutory goals for the nurse specialists provider class plan for the two year period under review, a change in the plan is not required because, as discussed in the body of this report, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve all of the goals is reasonable, due to factors listed in Section 509(4).

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the nurse specialists provider class plan for the calendar years 2006 and 2007.

In addition to the final determination, this report will: define a provider class plan, explain the statutory review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings, which support that determination.

Provider Class Plans - Legal Background

Section 107(7) of the Act, defines a provider class plan as "a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers includes not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for services provided to a BCBSM member.

2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.

3. BCBSM must compensate providers in accordance with reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Section 509(4) of the Act requires the Commissioner of the Office of Financial and Insurance Regulation (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM, which pertain to each respective provider class;

2. Comments received from subscribers, providers, and provider organizations;

3. Health care legislation;

4. Demographic, epidemiological and economic trends;

5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations pursuant to Section 510(1) of the Act:

(a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.

(c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. If after six months or such additional time as provided for in Section 512, BCBSM has failed to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the Nurse Specialists Provider Class Plan

The nurse specialists provider class for BCBSM covers the services provided by certified nurse midwives (CNM), certified nurse practitioners (CNP) and certified registered nurse anesthetists (CRNA). CNMs are limited to basic ante partum care, normal vaginal deliveries and postpartum care. CNMs are reimbursed for deliveries only when the delivery occurs in the inpatient hospital setting or in a hospital-affiliated birthing center that is owned and operated by a participating state licensed and accredited hospital. CNPs are reimbursed for a broad range of services including complete physicals, health assessments, treatment of common acute illnesses and chronic stable medical conditions, and psychiatric services. CRNAs are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of peer groups 1-4 hospitals, peer group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities.

For the period 2006-2007, payments to nurse specialists represented an average of 1.6% of the total benefit payments made to health care providers on behalf of BCBSM members. For the purpose of provider class plan reviews by the Office of Financial and Insurance Regulation (OFIR), paid claims data are categorized by nine geographic regions. A map, which depicts these geographic regions, is included in Attachment A.

Nurse specialists are subject to certain qualification standards set by BCBSM. BCBSM's nurse specialists provider class plan indicates providers must meet the following basic qualifications:

- A current Michigan license as a registered nurse
- Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review
- Absence of fraud and illegal activities
- Each nurse specialist must also meet the following additional standards that apply to their specialty:

  Certified Nurse Midwives must have and maintain:

  - Current national certification by the American College of Nurse Midwives, American Midwifery Certification Board or another nationally recognized nurse midwife certifying entity recognized by the Michigan Board of Nursing
  - Current nurse midwife specialty certification issued by the Michigan Board of Nursing

  For CNMs performing deliveries, the following items are also required:

  - Written confirmation of an established relationship for medical consultation, collaboration or referral with an obstetrician/gynecologist (Ob/Gyn) or a qualified physician, if access to an Ob/Gyn is not available. A qualified physician is an

MD/DO such a perinatologist, family practice physician or internist with a women's health practice that corresponds to that of the CNM. The Ob/Gyn or otherwise qualified must have Ob/Gyn admitting privileges at the hospital or hospital-affiliated birthing center where the CNM will practice.

- Written confirmation of established privileges with hospital(s), or hospital-affiliated birthing center(s), or written confirmation of emergency and hospital admission arrangements with a consultant physician who has admitting privileges.

Certified Nurse Practitioners must have and maintain:

- Current certification by a nationally recognized certifying entity recognized by the Michigan Board of Nursing. This presently includes the following:
  - American Nurses Credentialing Center
  - National Certification Corporation for the Obstetric/Gynecologic and Neonatal Nursing Specialties
  - Pediatric Nursing Certification Board
  - American Academy of Nurse Practitioners
  - Oncology Nursing Certification Corporation
  - Current nurse practitioner specialty certification issued by the Michigan Board of Nursing

Certified Registered Nurse Anesthetists must have and maintain current national certification from the Council on Certification of Nurse Anesthetists or current recertification form the Council on Recertification of Nurse Anesthetists. CRNAs also must have current nurse anesthetist specialty certification issued by the Michigan Board of Nursing.

The following definition applies to the reimbursement methods for all nurse specialists:

Billed Charge – the billed charge refers to the actual charge indicated on the claim form submitted by the provider.

The following definition applies to the reimbursement methods for CNMs and CNPs:

Maximum Payment Level – Most of BCBSM's maximum payment schedule is based on the Resource Based Relative Value System (RBRVS) developed by the Centers for Medicare and Medicaid Services, in which services are ranked according to the resource costs needed to provide them.

The resource costs of the RBRVS system include physician time, training, skill, risk, procedure, complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The

relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Other factors that may be used in setting maximum payment levels include comparison to similar services, corporate medical policy divisions, analysis of historical charge data and geographic anomalies. BCBSM will give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level. BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy. BCBSM reviews relative values and reimbursement levels periodically and may adjust them as necessary.

An alternative reimbursement arrangement is available to groups through the Medical Surgical 90 program. The MS-90 program increases reimbursement levels for purposes of reducing out-of-pocket payments in regions where participation rates are low. For each covered service performed, BCBSM will pay the lesser of the billed charge or the maximum payment level for allowable procedures.

CNMs are reimbursed for deliveries only when the delivery occurs in the inpatient hospital setting or in a hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital. Allowable procedures for CNMs are limited to basic ante partum care, normal vaginal deliveries and postpartum care. CNMs are paid 100% of BCBSM's maximum fee schedule for these services.

For each covered service performed, BCBSM will pay CNPs who directly bill BCBSM the lesser of the billed charge or 85% of the maximum payment level.

BCBSM states CNPs and CNMs have been eligible to directly bill BCBSM since the 1990s. The rationale for implementing direct billing by CNPs and CNMs was to be consistent with Medicare billing practices. BCBSM states it issued a reimbursement clarification for CNPs on April 1, 2008 to explain the requirements for indirect and direct billing for services rendered by non-physician practitioners, including CNPs and CNMs. The policy clarification was issued in response to a request from the Michigan Nurses Association.

Direct billing refers to the billing of services under the provider identification number of the practitioner who performed the service. Indirect billing describes billing for services rendered by the non-physician practitioner under the provider identification number of the supervising or collaborative physician. BCBSM states that CNPs and CNMs are to report services using the direct billing method unless any one of the following criteria for indirect billing is met. The criteria include: 1) any service where the physician delivers any component of the service; 2) services for which the physician has provided specific clinical direction to the non-physician practitioner prior to or during the service; and 3) services for which the CNP has presented pertinent clinical findings and obtained approval of evaluation and management by the physician prior to the end of the day following the service. The involvement of the collaborative physician establishing the basis for indirect billing must be documented in the medical record.

CRNAs are reimbursed for anesthesia services performed in an approved setting. Approved settings include the inpatient or outpatient setting of Peer Group 1-4 hospitals, Peer Group 5 hospitals if the CRNA service is not included in the facility payment, and ambulatory surgical facilities. Services are only approved when personally performed within the CRNA's scope of practice.

BCBSM will pay CRNAs the lesser of the billed charge or a fee based on an anesthesia formula less copays or deductibles. The fee is calculated by multiplying a regional conversion factor by the sum of time (in 15-minute units) plus anesthesia base units (ABUs), which is then multiplied by a percentage factor. The percentage is 40% when the service is performed under the medical direction of a physician responsible for anesthesia services, who is not the operating surgeon, and 85% when the service is performed without medical direction of a physician who is responsible for anesthesia services and who is not the operating surgeon. The calculation may be stated as:

Fee = [(# time units + ABUs) x BCBSM regional conversion factors] x percentage (that is 40% or 85%).

ABUs are obtained from the Centers for Medicare & Medicaid Services; however, BCBSM retains the option to modify them at its discretion. The conversion factors used to derive the fees will be based on geographic area, with the goal of equalizing payment levels by geographic area over time.

Retroactive Payments

After a CRNA obtains Nurse Anesthetist Specialty Certification from the Michigan Board of Nursing, the CRNA's participation contract will be retroactive to the date the CRNA initially received national certification from the Council on Certification of Nurse Anesthetists. Retroactive reimbursement is available only to CRNAs upon their initial certification. Covered services rendered after national certification has been obtained will be reimbursed if the requirements of the members' benefit plan and the CRNA's contract with BCBSM have been met.

BCBSM is required to include as part of each provider class plan its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the nurse specialists provider class plan are to:

Access:

- Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.

- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration.
- Maintain and periodically update a printed or web site directory of participating providers.

Quality of Care:

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards.
- Meet with specialty liaison societies to discuss issues of interest and concern.
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes regarding utilization review audits.

Cost:

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions.
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participation agreement.

History of the Nurse Specialists Provider Class Plan

On June 7, 1991, BCBSM first filed with OFIR its certified nurse midwives provider class plan pursuant to Section 506(1) of the Act.

Section 506(2) states:

"Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."

Section 506(2) further states:

"For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the certified nurse midwives provider class plan met the filing requirements of Section 506 of the Act stated above, OFIR notified BCBSM by letter on June 11, 1991 that the certified nurse midwives provider class plan was placed into effect and retained for the Commissioner's records pursuant to Section 506(4).

On May 11, 1993, the certified nurse midwives provider class plan was modified to include a pilot project for the direct reimbursement of certified nurse practitioners. This modification resulted in the plan being renamed the nurse specialists provider class plan.

The nurse specialists provider class plan was modified by BCBSM on February 6, 1995 and June 24, 1996 to reflect changes in the participation agreements with respect to BCBSM's participation in the Inter-plan Teleprocessing System and the disclosure requirements of the Blue Cross Blue Shield Association.

BCBSM's nurse specialists provider class plan was modified by BCBSM on October 29, 1997 to include direct reimbursement to certified registered nurse anesthetists. BCBSM revised the appeals process available to non-hospital, non-physician participating providers on December 26, 1997. On December 29, 1998, BCBSM filed modifications to the nurse specialist provider class plan to convert the certified nurse practitioner pilot program into a permanent program. BCBSM filed a new contract for certified nurse midwives that included a resource based relative value reimbursement methodology on January 13, 1999. On April 26, 2002, BCBSM filed modifications to the reimbursement methodology for anesthesia services and updated qualification standards for nurse specialists. BCBSM filed another modification to the nurse specialist provider class plan on August 8, 2003 to allow payment to certified nurse anesthetists retroactively to the date the CRNA initially receives national certification. On August 14, 2006, BCBSM filed modifications to the nurse specialists provider class plan to delete the inpatient restriction for CNPs, remove the hospital affiliation requirement for CNMs and clarify language pertaining to birthing centers.

Review Process

On July 23, 2007, the Commissioner issued Order No. 07-042-BC, which provided written notice to BCBSM, health care providers, and other interested parties of his intent to make a determination with respect to the nurse specialists provider class plan for calendar years 2006 and 2007. Order No. 07-042-BC also called for any person with comments on matters concerning the provider class plan to submit such comments to OFIR in accordance with Section 505(2) of the Act. Section 505(2) requires the Commissioner to establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. Requests for testimony on BCBSM's nurse specialists provider class plan were sent to all those on OFIR's interested persons list for the nurse specialists provider class and posted on OFIR's website, providing interested parties three months to prepare and submit testimony.

Summary of Written Input:

Requests for written testimony regarding the nurse specialists provider class plan were sent to those on OFIR's interested persons list, including the Michigan Nurses Association, and posted on OFIR's website. Only one certified nurse midwife provided comments to OFIR.

The provider states CNMs are restricted by BCBSM to billing/reimbursement only for obstetrical and postpartum care. CNMs are not allowed to bill directly for any care that is provided that falls outside of those specific areas. For many CNMs this is not a big issue because they simply bill their services through their consulting/employing physicians or health care institution. For truly independents CNMs, BCBSM's policy is a huge problem.

CNMs are educated, authorized and licensed to provide women's health care (with a consultation agreement with a physician). This includes care during pregnancy as well as gynecologic care including annual exams, care for women experiencing infections and menstrual problems, women during menopause (including hormone replacement therapy and other medications as delegated by physicians). CNMs also provide primary care for issues such as bladder infections, and general physical exams and education, including preventative care and teaching. BCBSM does not, however, cover these services. Through liaison meetings with BCBSM, BCBSM has assured CNMs it agrees with CNM's broader definition of its scope of care, but BCBSM has yet to make the appropriate computer/billing changes to address the problem. CNMs must explain to patients that if the patients are pregnant with a bladder infection that CNMs may treat the patient and BCBSM would pay for their care. But it is difficult to tell patients who are not pregnant that although they may choose to see a CNM for care, because they are not pregnant, BCBSM will not pay for the same care that they may have received while they were pregnant. CNMs are still the same providers with the same skills, education and BCBSM credentials but may not receive BCBSM reimbursement for basic primary care services. This policy results in patients having to choose to continue with the CNM who delivered their baby and provided excellent care to them and pay for the care themselves or go find another provider after their six week postpartum visit.

The provider states that it is not uncommon for many women to have contact with the health care system only if they are having problems or for an annual pap exam. It is important to keep women in the health care system, continue their education and provide preventive care. CNMs have restrictions regarding the types of services they can provide and all advanced practical nurses (APNs) have restrictions on which services they are able to provide will be covered based on individual contracts with employers, particularly the auto customer groups. The provider believes that if a service is covered in their contract, then it should cover the entire scope of care that provider is qualified to provide. So, if a woman has coverage for an annual exam, she should be able to seek such care with any suitably licensed care provider.

The provider acknowledges receipt of the *Record* publication and has access to the provider information on BCBSM's website. BCBSM has started publishing nurse practitioner information in its web site but the directory is difficult to access and does not include any reference to the limitations on reimbursement so patients know what it covered and what is not. The provider notes BCBSM had an APN liaison group which met quarterly. These meetings were very helpful in communicating policy issues and changes in both directions. The group was disbanded, however. CNMs are told that they have a representative to work with but do not have a provider liaison because they are not physicians.

The provider states BCBSM's established standards of care are appropriate as well as claims processing time, information available or explanations on dispute claims. BCBSM is just beginning to track APN's directly for quality and outcome measures. As more APN's are credentialed and billed directly, it will give everyone a better idea of quality issues and standards. The provider does not believe BCBSM acts properly on changes that have taken place in the health care industry. Midwifery is recognized by nearly all other insurers as appropriate providers of gynecologic and minor primary care. Medicare, Medicaid, Aetna, Humana, PHP, Priority Health, PPOM [Cofinity], Tricare and so many other carriers cover all primary care services. Allowing women to seek care with the CNM does not increase costs or diminish quality. Women are typically allowed one annual exam per year and they will not seek to have such exams twice. Non-health maintenance visits would still be sought from the appropriate provider. Preventative care saves money and improves health outcomes so encouraging/enabling women to seek this type of care from the provider they are comfortable with simply makes sense.

The provider states BCBSM's reimbursement arrangements clearly comply with the cost goal in that BCBSM made credentialing and billings changes over the past few years that significantly decreased APN reimbursement, assuring APN's reimbursement is less than other providers. CNPs (and physician assistants) are paid at 85% of BCBSM's maximum fee screen. CNMs currently receive the same payment as physicians for obstetrical care but it is assumed CNMs will receive 85% of the allowable charge as well if and when CNMs are also allowed to provide for gynecological care. The provider notes that in the sense of customer groups seeing APNs as a cost savings feature, the lower reimbursement makes sense. However, particularly for preventive care, APNs are notably better at educating and helping clients implement healthy changes. As such, APNs should be paid on par with their physician colleagues.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act states that "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to nurse specialists services covered under the terms of that member's certificate whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIR staff examined several aspects of how access to specialized nursing services could be obtained, including the formal participation rates and service benefit level rates of providers, to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

Formal participation rates for BCBSM are derived by comparing the number of BCBSM participating providers to the number of providers registered with BCBSM throughout the state of Michigan. BCBSM uses the number of registered providers to determine its participation rates rather than the licensed nurses on file with the Department of Community Health because there is no way to determine from that data the number of licensed nurses who actually practice nursing within the state. The following information, supplied by BCBSM in July 2008 shows the number of Michigan participating nurse specialists, by certification type, and membership by geographic region for calendar years 2006 and 2007:

Nurse Specialists Provider Class Plan
Formal Participation Rates by Type

	2006			2007		
	No. of Par Providers	Total Registered Providers	Par Rate %	No. of Par Providers	Total Registered Providers	Par Rate %
CNM	144	146	98.6%	144	146	98.6%
CNP	1,299	1,393	93.3%	1,456	1,544	94.4%
CRNA	1,771	1,908	92.8%	1,861	2,001	93.0%
Statewide	3,214	3,447	93.2%	3,461	3,691	93.8%

As illustrated above, the nurse specialists' formal participation rates ranged from 93.0% to 98.6% during the two year period under review.

Another way to measure participation rates is to look at per-claim participation. The term "service benefit participation rate" refers to the percentage of services paid to providers participating with BCBSM on either a formal or per-case basis who accepted BCBSM payment as payment in full. BCBSM allows certified nurse midwives and certified registered nurse anesthetists to participate with BCBSM on either a formal or per-claim basis. Certified nurse practitioners are permitted to participate with BCBSM only on a formal participation basis. BCBSM cites that its no per-claim participation requirement policy for CNPs was made in order to encourage this provider type to formally participate and ensure access to services. BCBSM states it has no current plans to revise the policy. The service benefit participation rates for CNMs and CRNAs are shown below.

Nurse Specialists Provider Class Plan
Service Benefit Participation Rates

CNM	2006	2007
Paid in Full Services	2,438	2,454
Total Services	2,482	2,507
Service Benefit Rates	98.2%	97.9%

CRNA	2006	2007
Paid in Full Services	239,411	248,053
Total Services	240,138	248,876
Service Benefit Rates	99.7%	99.7%

The data reveals that per-claim participation rates for certified nurse midwives and certified registered nurse anesthetists during 2006 and 2007 remained stable at more than 97% for each nurse specialist category during the two year period under review.

BCBSM states it currently does not actively monitor per-claim participation for nurse specialists. Historically, this type of monitoring was performed through a post payment process of all provider types, with non-compliant providers identified and subsequently educated about the statutory requirements. BCBSM states the need for this process eventually diminished as the volume of non-compliant providers decreased. BCBSM states if it is notified or a violation of the per-claim participation policy comes to its attention, BCBSM works with a provider to correct it.

A review of nurse specialists' participation by geographical area was also supplied by BCBSM:

Nurse Specialists Provider Class Plan
2007 Combined Participation Rates by Region

	2006			2007		
	No. of Par Providers	Total Providers	Par Rate %	No. of Par Providers	Total Providers	Par Rate %
Region 1	1,523	1,580	96%	1,654	1,714	96%
Region 2	350	372	94%	8	14	95%
Region 3	166	168	99%	11	13	98%
Region 4	178	184	97%	7	7	96%
Region 5	273	343	80%	18	22	81%
Region 6	267	293	91%	25	26	93%
Region 7	245	256	96%	19	23	96%
Region 8	146	158	92%	8	8	96%
Region 9	67	94	71%	14	14	70%
Statewide	3,215	3,448	93%	218	370	94%

The above data illustrates the statewide combined participation rate increased 1% from 2006 to 2007. The regional participation rate was 80% or greater in all regions except for in region nine (Upper Peninsula with the exception of Mackinac and Chippewa Counties) where the participation rate was around 70% during the two year period under review. The participation rate for the Upper Peninsula was the result of an average participation rate of 98% for CNPs and 50% for CRNAs. BCBSM states that although the average par rate for CRNAs in the region nine was lower than in all other regions, the number of CRNAs increased from 54 in 2006 to 58 in 2007 and the per-claim participation rate for these providers was 99.7%. BCBSM states there are no CNMs registered or participating in the region nine. According to data provided by the Michigan Department of Community Health (MDCH) Board of Health Professions, there are only two CNMs licensed in the same region. MDCH's data does not indicate if the two CNMs are employed, but does indicate that they are active and able to practice. It is not uncommon for nurses to maintain their license but be employed in occupations other than nursing.

BCBSM provided a regional map showing the location of participating nurse specialists by county for 2007. Review of this regional map reveals that most of the nurse specialists, as one would expect, practice in urban locations. All but seven of Michigan's 83 counties have at least one nurse specialist.

BCBSM encourages its members to confirm the participation status of providers before they receive services. In addition to checking with individual providers, BCBSM can obtain current participating provider information by calling BCBSM's toll-free customer service number or checking BCBSM's website at www.bcbsm.com. BCBSM regularly updates its website directory and thus provides a great resource to BCBSM members seeking out physician and professional providers. Nurse specialists are included in BCBSM's online directory. Although provider testimony and BCBSM provider liaison minutes from 2006 indicated the online directory was not user friendly and difficult to access, testing of the provider directory during this review process revealed no problems at this time with the ability to verify BCBSM affiliation status of nurse specialists so such difficulties appear to have been resolved. BCBSM states it also will provide BCBSM members a printed version of the provider directory if they request one. Specialty nurses are listed as ancillary providers in the printed directory.

In 2006, additional procedures became payable to CNPs, including reimbursement to CNPs for specific inpatient services effective October 1, 2006 and for specified psychiatric services effective June 26, 2006. These services automatically became payable benefits to those BCBSM customer groups that recognize CNPs as eligible providers. CNPs are reimbursed 85% of the physician maximum payment amount when they bill directly for these services. The expansion of these benefits increased access to care from more qualified providers for BCBSM members.

BCBSM's communication efforts also impact access to care as it helps establish and maintain a good rapport with participating providers. BCBSM distributes to all providers a

publication called the *Record*. This monthly publication contains current information relating to billing, reimbursement, group-specific benefit changes, day-to-day business information and medical criteria modifications. The *Record* was created with input from provider focus groups as an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them.

In January 2007, BCBSM added an online service called "*Record Select*" that allows providers to select pertinent articles by category. The articles are compiled monthly. BCBSM notifies providers via e-mail when the articles become available. The articles can be reviewed online or downloaded and saved to a personal computer. BCBSM states more than 2,000 providers have signed up for this service and a specific article category has been created for each certified nurse specialty.

BCBSM states it offers providers the options of speaking with provider service representatives, writing to its inquiry department and having a provider consultant visit provider offices to help guide and educate their staff. BCBSM trainers also educate providers with seminars on various topics such as how to use web-DENIS, benefits, claims processing and adjustments, InterQual® and Medicare Advantage. Computer based training tools have also been developed to expand the reach of the training sessions.

In 2005, BCBSM expanded its web-DENIS system from a private access network of electronic self-service features supporting provider inquires to an Internet-based program via a new secured provider portal on www.bcbsm.com. This new program provides quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, reports and other types of required information designed to make doing business with BCBSM easier. BCBSM designed the Internet site to promote secure, effective and personalized use of the Internet for existing web-DENIS users and to encourage new providers to begin to use web-DENIS.

Easy-to-find links such as *Partner Links* were also added to BCBSM's Web-DENIS. *Partner Links* connects providers to BCBSM's partner sites, including the Council for Affordable Quality Healthcare, Institute for Safe Medication Practices, Michigan State Medical Society and the Michigan Health and Hospital Association.

BCBSM states in August 2005, it implemented the Internet Claims Submission Tool through web-DENIS. The tool allows providers who currently submit paper claims to submit them online for processing. The tool provides a low cost alternative to smaller practices that are not interested in purchasing expensive software to bill electronically through conventional means. In addition to its convenience and cost savings, the Internet Claims Submission Tool offers providers a faster response time than paper claims. In March 2007, web-DENIS also added capability to respond to requests from providers for specific service type information regarding members of other BCBS plans. As a result, a provider can request and receive specific member benefit information, such as eligibility, benefit limitations, patient liability and coverage by place of service.

Another avenue for nurse specialists to obtain needed information from BCBSM is CAREN^{+}, an integrated voice response system which provides information on eligibility, benefits, deductibles and co-payments. In 2006, CAREN^{+} was enhanced to include interactive voice response technology that enables providers to enter contract numbers by voice or text. New security measures were also added to CAREN^{+} to safeguard BCBSM's members' protected health information.

BCBSM has also instituted several provider affiliation strategy programs to foster an ongoing commitment to excellent performance and dialogue with providers. BCBSM states it promotes business relationships with providers so they will: 1) collaborate with BCBSM to improve the health status of patients and the quality and cost effectiveness of care; 2) help BCBSM deliver outstanding customer service to members; and 3) value BCBSM as a health plan of choice and recommend it to patients and others. The provider affiliation strategy focuses on increasing provider satisfaction and creating a strong relationship with providers by providing a prompt and accurate claims payment system, consistent, accurate and responsive service; timely and effective communication, and partnerships to promote and facilitate better health care.

BCBSM initiated programs to improve the quality and timeliness of system changes to improve the percentage of claims reimbursed on the first submission and to reduce the number of initial claim rejections. This initiative has reduced the number of claims that are manually adjusted to process through BCBSM's claim system. BCBSM states claim rejections were reduced by 30% in select claims categories in 2006. The reduction is the result of clarification of billing and reimbursement guidelines, removal of unnecessary edits and the standardization of medical policy rejections.

During June to August 2007, BCBSM increased face-to-face feedback opportunities through provider outreach fairs. These fairs were held throughout the state, giving providers the opportunity to interact with BCBSM representatives to discuss web-DENIS, provider training, electronic data interchange and other issues. BCBSM states more than 2000 providers attended its outreach fairs during 2006 and 2007. Although BCBSM does require providers to sign in at the fairs, BCBSM does not track this information back to a particular provider type. Given BCBSM does not keep statistics on the types of providers attending its outreach fairs, BCBSM does not know how many nurses attended the fairs.

BCBSM's reimbursement methodology is designed to be equitable to ensure appropriate provider participation levels. Reimbursement policies, as described on pages four through six of this report differ for certified nurse specialty providers. BCBSM periodically reviews certified nurse midwife, certified nurse practitioner and certified registered nurse anesthetist provider reimbursement to determine if modifications are necessary, but does not guarantee this review process will result in increased reimbursement.

Provider testimony indicates that BCBSM has restricted access to certain services CNMs are permitted to do under the scope of their licenses. BCBSM currently only pays CNMs

for obstetrical and postpartum care despite the fact that CNMs are educated, authorized and licensed to provide both obstetrical and postpartum care and gynecologic care including annual exams, care for women experiencing infections and menstrual problems, women during menopause (including hormone replacement therapy and other medications as delegated by physicians). CNMs may provide primary care services for issues such as bladder infections, physical exams and education.

Section 416d of the Act became effective in October 2004 with respect to coverage for obstetrical and gynecological services by physicians or CNMs. Section 416d of the Act indicates that effective March 1, 2005, any group or nongroup certificate that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether such services are performed by a physician or CNM acting within the scope of his or her license or specialty certification or shall do one or both of the following:

a) Offer to provide coverage for obstetrical and gynecological services whether performed by a physician or CNM acting within the scope of his or her license or specialty certification.

b) Offer to provide coverage for maternity services and gynecological services rendered during pre-and post-natal care whether performed by a physician or CNM acting within the scope of his or her license or specialty certification.

Currently, BCBSM's certificates of coverage are in adherence with these statutory provisions by providing coverage for maternity services and gynecological services rendered during pre-and post-natal care when performed by a physician or CNM. BCBSM does agree, however, there should be a broader definition of CNMs' scope of care. BCBSM states the system changes necessary to expand coverage for CNM services have been put on hold because of other priorities that required BCBSM's more immediate attention. BCBSM now states the request for system changes to expand coverage for CNM services will be considered in 2009.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered services provided by nurse specialists, whenever such services are required. Based on the information analyzed during this review, BCBSM was able to maintain formal participation rates of over 80% with all three types of nurse specialists during the two year period under review. Further, CNMs and CRNAs accepted BCBSM payment as payment in full an average of 97% of the time during the same time period. As such, it is determined that BCBSM generally met the access goal stated in the Act for calendar years 2006 and 2007. Given BCBSM agrees there should be a broader definition of CNMs' scope of care, BCBSM should make a conscientious effort to actually implement the necessary system changes for CNMs during calendar year 2009.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, OFIR staff examined BCBSM's achievement of its quality of care objective, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's methods of communication with nurse specialists. We reviewed these factors to assure that BCBSM not only encouraged provider compliance with the expected standards of nurse specialists services, but also that it kept abreast of new technological advances available to treat those BCBSM members that require such services. All of the above factors impact the quality of the services nurse specialists delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review period, are described below.

BCBSM has taken a twofold approach to achieving its quality of care objectives for the nurse specialists provider class. First, BCBSM attempts to promote the quality of health care delivered by providers through the enforcement of provider qualifications and utilization review programs and by providing nurse specialists with incentives to improve the quality of care. Second, BCBSM strives to forge strong relationships with participating providers by designing programs directed toward effective servicing and communication.

To ensure acceptable levels of care provided by nurse specialists, BCBSM requires that these providers meet the participation qualifications and performance standards listed on pages three and four of this report. BCBSM states that provider qualification status is continually monitored to ensure subscriber access to competent providers who are not involved in fraud or illegal activities.

Physician oversight is no longer a participation requirement for nurse practitioners and certified registered nurse anesthetists. BCBSM states it follows the Michigan Department of Community Health (MDCH) and the Michigan Board of Nursing (MBN) with respect to standards of practice for nurse specialists. MDCH and MBN-recognized national certifying agencies do not require nurse anesthetists or nurse practitioners to have a relationship with a physician or to have hospital admitting privileges. If a patient of a nurse practitioner requires hospitalization, BCBSM relies on the professional judgment of the nurse to refer the patient to the appropriate setting or practitioner.

In response to provider testimony regarding BCBSM only recently began credentialing nurse specialists, BCBSM states that nurse specialists who request participation status and meet the qualification standards outlined in the provider class plan are registered as a provider with BCBSM as a traditional provider. BCBSM does not have an extensive credentialing process in place similar to those established for its PPO network and the mandated credentialing process in place for its HMO subsidiary, Blue Care Network (BCN).

To become accepted into BCBSM's PPO network or its HMO subsidiary, Blue Care Network (BCN), a provider must undergo a credentialing process that is more extensive than the enrollment process used under BCBSM's traditional program. BCN began credentialing nurse specialists in March 1999. BCN also began credentialing nurse specialists considering affiliation with the University of Michigan Health Clinic in March 2007. BCBSM's HMO and PPO provider network credentialing processes are not subject to review under Part 5 of the Act.

BCBSM remains committed in its efforts to improve the heath status of Michigan residents by focusing resources on areas of greatest importance where BCBSM is uniquely positioned to deliver results and consequently reduce health care costs. BCBSM executed and publicized health initiatives that focus on critical health issues such as: 1) community programs addressing geographic, racial and ethnic disparities; 2) programs designed to improve the health status of children; 3) programs designed to address obesity and smoking cessation programs; 4) depression awareness; and 5) domestic violence and abuse.

BCBSM also sponsors programs such as *Walking Works™*, a wellness program designed to promote good health, and *Healthy ME!™*, a free program for Michigan elementary schools that blends facts about healthy lifestyles with friendly characters, upbeat songs and humor. It is hoped that by encouraging kids to adopt healthier, more active lifestyles now, these programs will help control health care costs in the future.

BCBSM also offers a 24-hour Nurse Line. The 24-hour Nurse Line services members who are engaged in preventive health efforts, interested in making decisions about acute health issues related to injury or illness or managing less complex medical conditions. The goal of Nurse Line is to educate and assist BCBSM members about health issues, managing their symptoms and making informed decisions about their health.

BCBSM states it has one of the largest repositories of health care utilization data in the United States. BCBSM pays a key role in bringing health care value to its customers and the community by utilizing its abundant source of data for health research and analysis. BCBSM's analysis of local data has led to successful partnerships with area health systems, health coalitions and community health initiative programs. Examples of these collaborative efforts include the Michigan Quality Improvement Consortium and the Michigan Health and Safety Coalition. The Michigan Quality Improvement Consortium is a group of health plans, physicians, quality improvement organizations and medical societies that works to develop a single source of quality improvement guidelines for the treatment of certain conditions and the measuring of health care provider performance. The Michigan Health and Safety Coalition leads and supports a diverse group of providers, including several nurses, that work to develop solutions to patient safety problems. BCBSM states in 2004, Governor Granholm asked this coalition to be Michigan's Commission on Patient Safety.

BCBSM states data management and clinical analysis of health care information are critical components of being a market leader. By providing those elements, BCBSM positively impacts the quality of care in the community and supports its mission of excelling in the delivery of health care products and services.

BCBSM also monitors provider performance through its utilization review process. Audits are typically performed when BCBSM's Corporate and Financial Investigations Department identifies potential abuse, billing issues are noted or the result of member complaints. These professional review audits can determine if services were medically necessary and rendered in accordance with members' benefits. BCBSM auditors use InterQual Procedures Criteria that is subject to BCBSM medical policy, benefit policy and payment policy to review and approve services. If a service cannot be approved using these criteria, the auditor refers the service to a BCBSM medical consultant for review. BCBSM medical consultants use national society guidelines and current practice parameters, when available, to approve services. If the consultants cannot approve a service using the current guidelines and standards, they use their medical education, training and experience to make the audit decisions. This peer review process is conducted by medical consultants with the same or similar specialty as the provider being audited. After this two step review of medical record documentation, BCBSM may seek recovery of payments from providers whose documentation fails to meet the guidelines.

During utilization review audits, paid claims data and the corresponding medical records are reviewed to ensure that nursing services were appropriate and the services rendered were performed for the appropriate indications, in appropriate settings and were accurately billed and paid. At the conclusion of the audit, a departure conference with the provider, led by a BCBSM auditor, provides preliminary findings identified in the audit. The departure conference also serves as an opportunity for education. Methods to enhance correct coding and billing practices are discussed and providers are encouraged to build on existing strengths.

BCBSM states it did not audit any nurse specialists during the two year period under review as BCBSM was not aware of any utilization issues, potential abuse of member complaints. Nurse specialists have been audited in the past but no real issues were found.

Another measure of BCBSM's achievement of the quality of care goal includes BCBSM's ability to effectively communicate with providers. Given that the quality of care goal defined in the Act requires that "providers meet and abide by reasonable standards of health care quality," it is necessary for providers to be made aware of BCBSM's standards, for BCBSM to verify that its providers adhere to such standards and that BCBSM is responsive to provider inquiries, input, and appeals, as all of these factors impact the quality of specialized nursing services given to BCBSM members.

The interests of nurse specialists are currently represented by the Michigan Nurses Association (MNA). BCBSM met with MNA twice during 2006 and once in 2007. These liaison meetings are dedicated to the resolution of issues of dispute in order to improve the

quality of nursing services delivered to BCBSM members. The minutes of these meetings were obtained from BCBSM for review. Items discussed at these liaison meetings included indirect CNP billing guidelines and CNM reimbursement and scope of practice issues.

Provider testimony expressed concern that the liaison group for nurse specialists had been disbanded. BCBSM has indicated that the responsibilities for nurse specialists changed hands during 2008 and a new nurse specialist provider liaison has been appointed. A nurse specialists' liaison group meeting for 2008 was scheduled for December 19, 2008.

BCBSM offered continuing nurse education seminars regularly, with the goal of having a positive impact on nursing practices and patient outcomes. The seminars offered an opportunity for participating nurse specialists to obtain current clinical information on a variety of topics. In 2006, seminars focused on managing migraine pain, a diabetes and endocrine update, women's cardiovascular health, autoimmune disease update, best practices, and updates on pharmacy and avian flu. Seminars offered in 2007 provided education on pain management, thyroid function and disorders, diet and exercise, hepatitis C, rheumatoid arthritis, Crohn's disease and preventive dental care. BCBSM states approximately 1,700 registered nurses attended its 2007 continuing education seminars.

BCBSM states that it maintains open communications with nurse specialists through its monthly publications, provider manuals, and its formal appeal process. All participating nurse specialists receive BCBSM's monthly publication of the *Record*. BCBSM states the issues discussed in this publication are those that often impact providers' practice patterns and the achievement of utilization performance standards. BCBSM also has regional field services representatives that are available for on-site, individualized provider education and to address problems and concerns. Providers also receive direct mailings from BCBSM announcing changes in benefit programs and requesting provider feedback.

As part of the review process, OFIR examined a copy of BCBSM's provider manuals for CRNAs and nurses obtained from BCBSM's Web-DENIS. These provider manuals, revised in September 2005 and continuously updated online, include information, such as participation requirements, patient eligibility requirements, pre-approval of services, benefits and exclusions, coordination of benefits, criteria and guidelines for services, documentation guidelines, claim submission information, and sections describing audit information, claims appeals processes, utilization review, and how to contact BCBSM departments for assistance.

BCBSM also maintains a provider appeal process for nurse specialists. The purpose of the appeal process is to resolve claim or audit disagreements. The appeal process is periodically published in the *Record* and is outlined in detail in both the online provider manual and the nurse specialists participating agreement.

There are many different levels of the appeals process. The provider starts with a routine inquiry to BCBSM and can follow with a written complaint asking for a reconsideration

review. If the provider is not satisfied with the reconsideration, he or she may submit a written request for a Managerial-Level Review Conference. During this conference, BCBSM and the provider discuss the dispute in an informal setting and explore possible resolutions of the dispute.

If the provider is dissatisfied with the managerial-level review, the provider can continue with BCBSM's appeal process, appeal to OFIR, initiate legal action, or if medical necessity issues are in dispute, request an external peer review for medical necessity issues. If the provider requests an external peer review and the review is decided in favor of BCBSM, the provider will pay the costs of the external review. If the review is decided in favor of the provider, BCBSM pays the costs. If the findings are partially upheld and partially reversed, BCBSM and the provider share the costs of peer review in proportion to the results. The decision of the external review organization on medical necessity disputes is final and binding on both the provider and BCBSM.

For disputes involving administrative, billing and coding disputes, a provider may request a review by an internal review committee. BCBSM's Internal Review Committee is composed of three members of BCBSM senior management. If providers are unhappy with the Internal Review Committee decision, they can appeal to BCBSM's Provider Relations Committee. The Provider Relations Committee is a subcommittee of the BCBSM Board of Directors composed of BCBSM participating professionals, community leaders and BCBSM senior management.

Providers that go through BCBSM's appeals process and remain dissatisfied can appeal medical necessity issues and administrative and billing and coding issues to OFIR for an informal review and determination. If the provider remains dissatisfied, they can move to a contested case hearing pursuant to Section 550.1404(6) of the Act. Contested case hearing decisions are subject to appeal in the circuit court. No requests for OFIR informal review and determinations were received from nurse specialists during the two year period under review.

BCBSM states a nurse specialists' participation agreement may be terminated by BCBSM if the provider fails to meet any of the qualification standards. Providers must also have an absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and restrain from fraud and illegal activities. BCBSM may terminate a nurse specialist's participation agreement with or without cause by giving the provider 60 days written notice. The participation agreement can be terminated immediately by BCBSM if the nurse specialist fails to meet BCBSM's qualification standards. Nurse specialists may be recommended for departicipation from BCBSM if it is determined a provider is involved in the inappropriate use or billing of services, convicted of fraudulent or criminal acts involving BCBSM, Medicare, Medicaid or other third party carriers; whose license/certification is suspended or revoked; who refuse access to records for audit purposes and who are in violation of local, state or federal regulations, laws, codes, etc. No nurse specialists were departicipated from BCBSM during the two year period under review.

Findings and Conclusions - Quality of Care

In order to meet the quality of care goal, the provider class plan must assure that "providers will meet and abide by reasonable standards of health care quality." During calendar years 2006 and 2007, BCBSM required all nurse specialists to meet its qualification standards for participation and maintained communication with nurse specialists through its liaison meetings, educational seminars, monthly publications, appeal processes, provider manuals and online resources. Based on the information analyzed during this review, it is determined that BCBSM met the quality of care goal stated in the Act for the calendar years 2006 and 2007.

Cost Goal:

The cost goal in Section 504(1) of the Act states that "[P]roviders will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

After application of the cost formula found in Section 504 of the Act and using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure that will be used to determine BCBSM's achievement of the cost goal shall be as follows:

> The rate of change in the total corporation payment per member for the nurse specialists provider class for calendar years 2006 and 2007 shall not exceed 4.9%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + REG)]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percentage change in the implicit price deflator for GNP over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage change in per capita Gross National Product (GNP) in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the December 2007 population data obtained from monthly population estimates published by the Bureau of Census, as obtained from the U. S. Census Bureau (www.census.gov/popest/national/NA-EST2006-01.html), and economic statistics for the GNP and implicit GNP price deflator from the U. S. Department of Commerce, Bureau of Economic Analysis as published in June 2008 by the Federal Research Bank of St. Louis (research.stlouisfed.org/fred2/categories/18/downloaddata), the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

	% change in implicit GNP price deflator
2007	2.4
2006	3.2
2 yr. average	2.8

REG = Real Economic Growth as defined in the cost goal formula:

	% change in per capita GNP in constant dollars
2004	2.4
2005	2.3
2006	1.0
2007	2.3
4 yr. average	2.0

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 4.9%, as shown below:

Inflation = 2.8

Real Economic Growth = 2.0

$$\frac{[(100 + 2.8) \times (100 + 2.0)]}{100} - 100 = 4.9\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to OFIR, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions

prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4).

As stated in Section 504(2)(e) of the Act, the "'[R]ate of change in the total corporation payment per member to each provider class means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination." The cost and membership data for the nurse specialists provider class plan for the calendar years 2006 and 2007, as filed with OFIR by BCBSM, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

Nurse Specialists Performance Against Cost Goal

Nurse Specialists	2005	2006	2007	Average Yearly Rate of Change
Payments CNM	$710,203	$628,938	$615,861	(4.8)%
Payments CNP	$4,186,703	$4,838,342	$6,091,282	18.3%
Payments CRNA	$40,895,100	$44,222,541	$46,338,583	6.7%
Total Payments	$45,792,006	$49,689,820	$53,045,725	
Members (CNM)	2,586,467	2,479,394	2,476,734	
Members (CNP)	2,201,667	2,227,471	2,290,608	
Members (CRNA)	2,498,579	2,444,387	2,489,070	
Cost Performance				
Payments/1000 Members	$18,543.53	$20,517.25	$21,524.72	
Rate of Change (%)		10.60%	4.90%	**7.80%**

The two-year arithmetic average increase for the nurse specialists provider class plan equals 7.8%.

Overall health care cost performance shows the average increase in payments per 1000 members the result of annual increases in payments per 1000 members of 10.6% in 2006 and 4.9% in 2007. During the two year period under review the average number of members with nurse specialists remained relatively stable. While payment and use trends increased for the nurse specialty provider class, these trends varied significantly between the three nursing specialties, as shown below:

Nurse Specialists Provider Class

Provider Specialty	Pay/1000 Members	Serv/1000 Members	Pay/ Service	Three Year Payout	% of Total Payout	Contribution to Trend*	% Contribution to Trend
Certified Nurse Midwives	(4.8)%	(3.7)%	(1.0)%	$1,955,001.00	1.3%	(0.1)%	(1.0)%
Certified Nurse Practitioners	18.3%	8.7%	8.8%	$15,116,326.37	10.2%	1.7%	22.0%
Cert. Reg. Nurse Anesthetists	6.7%	5.1%	1.5%	$131,456,224.00	88.5%	6.0%	78.9%
Total	7.8%	6.2%	1.0%	$148,527,551.37	100.0%	7.6%	100.9%

*Contribution to trend is the two-year average rate of change in payments per 1000 weighted by the ratio of 2005 payments for each nurse specialist to 2005 total nurse specialist payments.

This above data reveals the growth in the use of services was the major factor for the high payment trend and is the primary reason BCBSM did not achieve the cost goal for the nurse specialists provider class. The above data shows that payment and utilization trends varied significantly by nurse specialty, with CNPs showing the largest increases with an a18.3% increase in payments per 1000 members. This higher CNP trend was a result of an 8.7% increase in use and an 8.8% increase in payment per service. The CRNA payment trend increased at an average rate of 6.7% primarily as a result of higher use, which increased an average of 5.1% during the two year period under review. CNM payments per 1000 members declined 4.8%, the result of a 3.7% decrease in use and 1.0% decrease in payment per service.

As CRNAs received 88.5% of payments for specialized nursing services, these services were the primary driver of growth in the payment trend. CRNAs accounted for 79% of the payment trend while CNPs accounted for 22% of the increase. Payments to CNMs had a negligible impact on the payment trend given only 1.3% of the total payout was attributable to CNM services.

The table below shows how the mix of services contributed to higher payment trends. Anesthesia services were responsible for 76% of the growth in payments per 1000. Medical visits and other medical services (e.g. ultrasounds, TB skin tests, pH measurements, etc.) combined for almost 20% of the increase in payments.

Nurse Specialists Provider Class
2005-2007 Trends

	2005-2007				Two Yr Avg Rate of Change		
Type of Service	Payments	Services	% of Payments	% of Services	Payment/1000	Services/1000	% Cont. to Trend
Anesthesia	$131,281,580	713,214	88.4%	68.4%	6.7%	5.0%	76.3%
Medical Visits	$9,188,509	174,853	6.2%	16.8%	14.4%	9.1%	12.1%
Medical Services	$3,280,322	67,396	2.2%	6.5%	30.9%	15.9%	7.7%
Surgery	$1,237,213	25,944	0.8%	2.5%	20.8%	6.3%	2.0%
Psych/Sub Abuse	$784,253	14,304	0.5%	1.4%	12.9%	11.4%	0.9%
Consultation	$334,279	2,602	0.2%	0.2%	56.8%	45.4%	1.3%
Prof Component	$482,379	37,250	0.3%	3.6%	(15.0)%	(6.5)%	(0.9)%
Maternity	$1,768,997	3,607	1.2%	0.3%	(2.7)%	4.4%	(0.5)%
Other	$170,019	2,988	0.1%	0.3%	50.6%	21.4%	1.1%
Total	$148,527,551	1,042,158	100.0%	100.0%	7.8%	6.2%	100.0%

BCBSM states the cost and use trends of nurse specialists mirror national trends with respect to the growth of surgical and diagnostic procedures requiring anesthesia. According to the American Association of Nurse Anesthetists at www.aana.com, CRNAs administer anesthesia to over 26 million people a year in the United States. CRNAs practice in a variety of settings, including hospital surgical suites, delivery rooms, critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs health care facilities.

When anesthesia is administered by a CRNA, it is recognized as the practice of nursing; when administered by an anesthesiologist, it is recognized as the practice of medicine. Regardless of whether their educational background is in nursing or medicine, all anesthesia professionals give anesthesia the same way. By providing an alternative to physician services, CRNAs increase access to anesthesiology services at a reduced cost to BCBSM as CRNAs are paid by BCBSM at 85% of BCBSM's fee screen when services are performed without the medical direction of a physician. CRNAs performing services under the medical direction of a physician are paid 40% of the BCBSM's maximum fee screen.

The top diagnostic categories by payment for CRNAs were musculoskeletal disorders, digestive system disorders, neoplasms and genitourinary system disorders. These same categories were also the top diagnostic categories for all types of nurse specialists and accounted for 56% of payments to CRNAs and 48% of payments to all nurse specialists in

2007. The top procedures CRNAs provided anesthesia services for to BCBSM members in 2007 included intestinal endoscopic procedures, upper GI endoscopy, procedures of the knee joint, lower leg, ankle, foot, and shoulder joint and anesthesia for labor and cesarean deliveries.

The demand for anesthesia services will continue growing as the number of surgical procedures climbs. New technology, an aging population and higher rates of obesity are fueling ever growing surgery rates for musculoskeletal disorders, cancer and circulatory diseases. A study published in the April 2007 Journal of Bone and Joint Surgery predicts the demand for primary hip replacement would grow 174% by 2030 and for an initial knee replacement by 673%.[1]

BCBSM states that 79% of payments to nurse specialists were for services provided in a hospital based setting, with 28% of payments associated with inpatient care and 51% of payment associated with outpatient care. Eleven percent of payments were for office-based services with the remaining 10% of payments being associated with services rendered in an ambulatory surgical facility (ASF) setting.

Payments per 1000 increased for all service locations except the hospital inpatient setting where payments declined an average of 3%. Even though ASF payments increased at an average rate of 39.4%, hospital outpatient payments per 1000 had the largest impact on the average payment trend since the majority of services were performed in that practice setting. Outpatient hospital and office payments per 1000 grew an average of 10% and 10.9%, respectively.

Nurse Specialists Provider Class
Payments and Services per 1000 by Year
2005-2007

	2005-2007		Contribution to Trend	
Service Location	**Payments/1000**	**Services/1000**	**Payment Trend**	**Use Trend**
Inpatient Hospital	(3.0)%	(3.8)%	(13.6)%	(10.8)%
Outpatient Hospital	10.0%	5.5%	62.9%	40.2%
Office	10.9%	3.8%	12.7%	18.8%
ASF	(39.4)%	44.2%	32.5%	45.8%
Other	14.2%	10.6%	0.3%	0.7%
Total	7.8%	6.2%	*	*

*Given BCBSM membership varies by nurse specialist type (CNM, CNP, CRNA), payment and use rates were calculated separately and the results for each provider type totaled. Totaling these separate rates which had different denominators had a multiplier effect, thus the total trends do not equal 100%.

1 "Hip, Knee Replacement Surgery Rates Skyrocket Over 7 Years", Amednews.com, (May 5, 2008) at ama-assn-org/amednews/2008/05/05/hlsb0505.htm.

The growth in the nurse specialists' payment trend was primarily due to increased use of services. Utilization increased in all service locations except in the hospital inpatient setting where use declined 3.8%. These trends are consistent with the trends seen in other provider classes as many surgical procedures done in an inpatient setting ten to twenty years ago are now routinely done in an outpatient setting. The above data illustrates ASF use surged at an average rate of 44.2% during the two year period under review, with hospital outpatient use increasing an average of 5.5%. During the same time period, hospital inpatient use declined 3.8% while office use increased 3.8%. Increased utilization in the ASF and hospital outpatient service locations accounted for 86% of the growth in the use trend for nurse specialists.

As illustrated in the table below, only 9.7% of its members eligible for specialty nursing services actually obtained services from these providers. Members aged 55-64 had the highest use rates. These members represented 14.2% of the membership yet accounted for 28.3% of the patients. Members aged 45-54 had the second highest proportion of utilizing members. These findings are consistent with national trends showing people tend to use more health care services as they age. Health care spending is expected to grow to reflect generally higher per capita spending as the baby boomer generation ages and new health care technologies lengthen the average life span. These increased life expectancies will undoubtedly impact the number of people with chronic conditions, injuries and disabilities requiring continued medical treatment. Thus, increased costs in these age categories are seen as inevitable as older adults place increased demands on the nation's health and welfare systems.

Nurse Specialists Provider Class
2007 Patient Count and Payments by Age Category

Age Category	Membership % by Age	Patient Count by Age	Patients as a % of Members	% Distribution of Patients	2007 Payments	Percent of Payments
0-18	29.2%	30,965	4.1%	12.4%	$4,821,490	9.1%
19-34	19.5%	39,506	7.9%	15.8%	$8,304,060	15.7%
35-44	16.7%	38,614	9.0%	15.5%	$8,037,864	15.2%
45-54	19.0%	60,548	12.4%	24.3%	$13,020,486	24.5%
55-64	14.2%	70,605	19.3%	28.3%	$16,520,798	31.1%
65+	1.4%	9,236	26.5%	3.7%	$2,341,027	4.4%
Total	100.0%	249,474	9.7%	100.0%	$53,045,725	100.0%

BCBSM states the characteristics of a population can also affect the population's consumption of health care resources. Michigan residents aged 45-64 years comprised 26.1% of the state's overall population compared to 25% for the same age group in the

United States. Michigan's median age of 37.2 is slightly higher than the national median age of 36.4.

As health care spending in the United States continues to escalate, attention has begun to focus on the growth of chronic diseases in Americans as a major factor in rising health care costs. Over 125 million people suffer from at least one chronic illness, while 75 million of them have two or more. These illnesses account for over 75% of total health care spending.[2] BCBSM states that while chronic conditions today are already high, the proportion of the population affected by one or more chronic diseases is expected to grow. By 2025, chronic diseases will affect an estimated 164 million Americans – nearly half (49%) of the population.[3]

Most health care expenditures in the United States are incurred by a relatively small proportion of the population. The highest 10% of health care spenders account for about 70% of all health care expenses while the lowest 50% account for only 3% of expenditures.[4]

BCBSM states Michigan outranks most states in the percent of the adult population with chronic conditions such as obesity, diabetes, hypertension and cancer. According to a Forbes article on America's most obese cities, Detroit, Michigan ranks fifth with 30.4% of the population listed as obese.[5] Michigan continues to be one of the least healthy states in the nation and fares poorly with respect to the prevalence of lifestyle factors that contribute to chronic health conditions such as smoking, lack of exercise and diet. The result of so many Michigan residents with chronic health conditions like diabetes, hypertension and cardiovascular disease is increased health care costs. Because there is no single best solution, many approaches to control health care spending are being used, including provider pay-for-performance programs, consumer education, and the promotion of healthy lifestyles. Unfortunately, whereas promoting healthy lifestyles is indeed important, getting the general population to adopt and actually maintain a healthy lifestyle is what it will take to ultimately have a positive effect on health care costs in the future.

The causes of increasing health care costs in Michigan and nationwide are multiple and include: increasing use of cutting-edge technologies in medical diagnosis and treatment (e.g. minimally invasive hip replacements for patients suffering from osteoarthritis); significant advances in prescription drugs; demand by patients for new types of treatment and medications; people living longer; workforce shortages (e.g. nurses) that drive labor costs higher due to the need to pay overtime wages; soaring medical liability costs; and, increased patient volumes.

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[2] Meyer, Jack and Barbara Markham Smith, "Chronic Disease Management: Evidence of Predictable Savings" (November 2008), www.healthmanagement.com/files/Chronic%20Disease%20Savings%20Report%20final.pdf.
[3] "Chronic Conditions: Making the Case for Ongoing Care," Partnership for Solutions, September 2004 Update, available at http://www.rwjf.org/files/research/chronicbook2002.pdf.
[4] (Berk and Monheit, *Health Affairs*, 20(2): 9–18, 2001). http://www.rwjf.org/reports/grr/052594.htm
[5] Ruiz, Rebecca. "America's Most Obese Cities," http://www.forbes.com/2007/11/14/health-obesity-cities-forbeslife-cx_rr_1114obese.html.

There is a definite shift in the health care industry on both state and federal levels toward disease management programs as a way to control spiraling costs. Disease management aims at empowering participants to better manage and improve their own health, which in turn should help control costs of health care services. BCBSM states it has broadened its scope of medical care management design. BCBSM no longer directs all of its attention to provider costs and provider utilization but instead has developed member-focused health management programs.

BCBSM states its BlueHealthConnection® is an integrated care management program, addressing member needs relative to chronic conditions and health care decision support. Members have access to important clinical assistance and education tools to help make their own health care decisions. The program also involves the health care provider as part of the care process. BlueHealthConnection® is designed to control health care costs by empowering and educating members on how to maintain a healthy lifestyle.

BlueHealthConnection® provides members with 24/7 access to health information by telephone, mail or online access. Instead of organizing program outreaches around different conditions and diseases, target populations are stratified into four risk segments to allocate resources most efficiently and effectively. The highest risk segment receives the most contacts, on average, six to twelve mailings per year. The other three segments are the moderate high, moderate and low risk groups. Welcome letters, magnets, postcards, information sheets and invitation to call cards are some of the ways BCBSM reaches out to members.

BCBSM states with its implementation of the BlueHealthConnection® program, it has gone beyond traditional disease management and achieved a whole-person approach to care management. Members' needs are met by helping them cope with health conditions they and their loved ones are struggling to manage. The program allows BCBSM to become their health care partner and their advocate in addition to being a great source for health management information.

BlueHealthConnection® nurses help patients manage symptoms of minor illnesses or injuries, provide general information such as tips for healthy lifestyles or side effects of prescription drugs, manage chronic diseases, discuss treatment options, support weight loss and tobacco cessation efforts and provide case management for the very ill. BCBSM states its BlueHealthConnection® nurses also advocate for the appropriate care setting for recommended services. For example, a patient with a chronic disease, such as congestive heart failure, may be telephoned regularly to monitor the patient's weight. If a weight increase is noted, indicating fluid collecting in the lungs, the nurse would refer a patient to his or her physician for care or would call the patient's physician recommending administration of IV diuretics in the home. The nurse's involvement is effective because care is sought in a lower cost setting before further complications arise which might necessitate an inpatient admission.

Although BCBSM could not identify savings specific to the nurse specialists provider class, BCBSM states the BlueHealthConnection® program has avoided an average $30 million in health care costs each year since its launch in 2003, with savings of $33.9 million in 2006 and $36.6 million in 2007. As part of this program, BCBSM sends out Disease Management Customer Satisfaction surveys to program participants. BCBSM states 90% of the participants completing the surveys were satisfied with the program.

Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM did not meet the cost goal stated in the Act for the nurse specialists provider class during the two year period under review. This decision is based on the fact that the rate of change in the total corporation payment per member to the nurse specialists provider class has been calculated to be 7.8% over the two years being reviewed and therefore exceeded the compound rate of inflation and real economic growth of 4.9%.

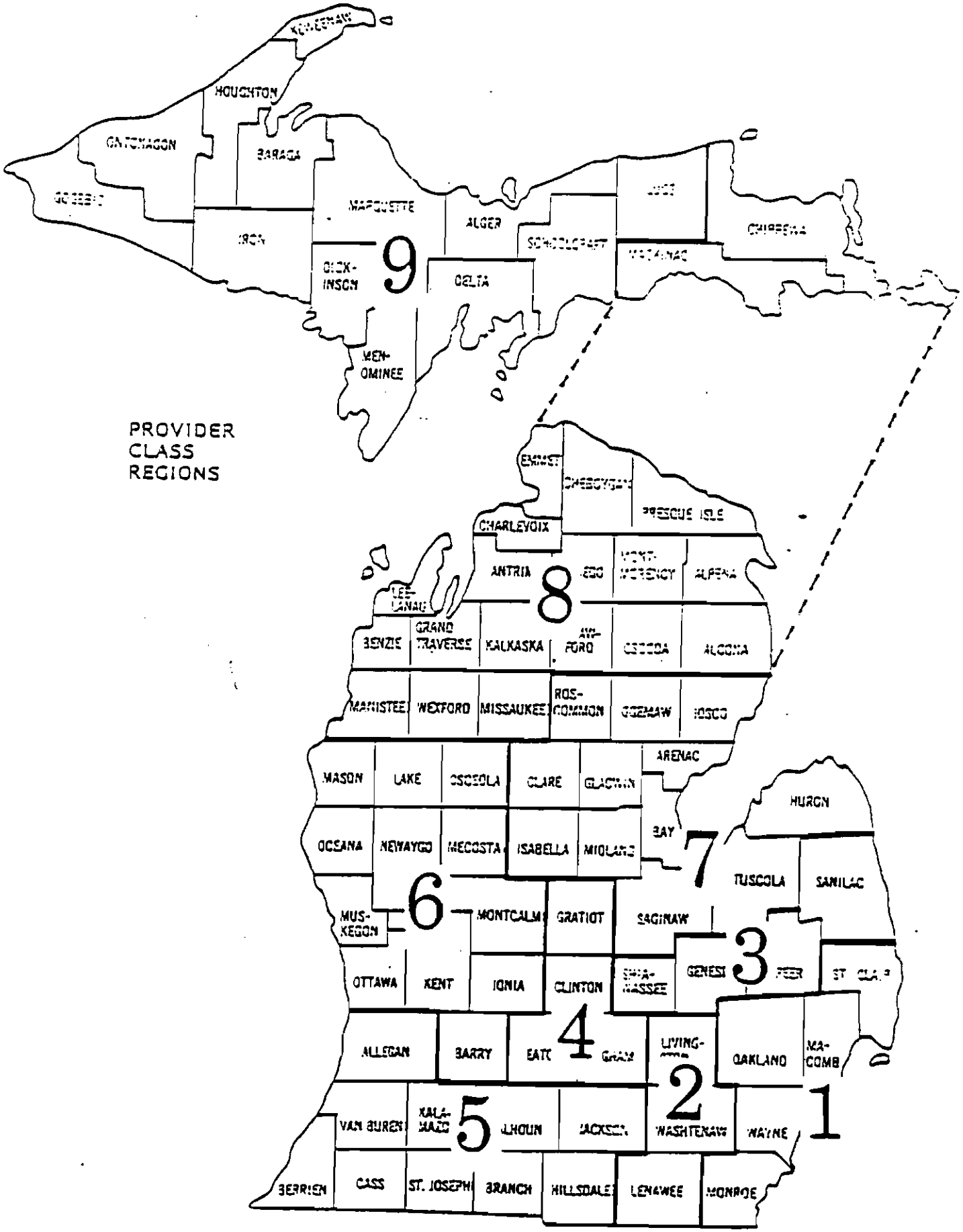
BCBSM made available a variety of programs in an effort to control specialty nursing costs as well as overall health care costs generally during the two-year period under review, including its BlueHealthConnection®, *Walking Works*™, and Healthy ME!™ programs. Yet, there are other factors that impact BCBSM's ability to contain costs within the constraints of the cost goal specified in the Act. The most prominent factors include an aging population and the overall health status of Michigan residents. Michigan residents are living longer because of the development of cutting-edge technologies in medical diagnosis and treatment and the significant advances made in prescription drugs used to treat chronic illness. Increased longevity also increases the likelihood for Michigan residents to develop chronic conditions for which they seek out health care services. Because people with chronic conditions tend to have greater health care needs and are the most frequent users of health care services (regardless of age), the costs associated with these needs are disproportionately high.

Michigan ranks poorly care on most measures of lifestyle factors and health status measured related to the development of chronic conditions, including overweight and obesity, diabetes, hypertension, cardiovascular disease, smoking and lack of physical exercise. Growing rates of obesity and chronic health conditions will continue to fuel increased use of health care services and will continue to be a major driver of higher health care spending.

Because of this, it is not necessary to require that a change to the current nurse specialists provider class plan be filed pursuant to Section 511 of the Act. BCBSM is encouraged to continue its efforts to find new, innovative programs that instill responsible cost controls so that all the goals and objectives of the corporation can be achieved.

Determination Summary

In summary, BCBSM generally achieved two of the three goals of the corporation during the two-year period under review for the nurse specialists provider class. Although the nurse specialists provider class did not substantially achieve the cost goal, a change in the plan is not required because, as outlined above, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve the cost goal was reasonable, due to factors listed in Section 509(4).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